MULTIPLE CANCER OF THE COLON

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A 68 year old woman was admitted to St. Luke's Hospital on 1.12.73 on account of severe colicky pain in the right iliac region of the abdomen of 14 hours duration. She had vomited three times and her bowels had moved also three times but the stools were of normal colour and consistency. She had no other complaints and prior to this bout she had enjoyed good health and appetite and had had no abdominal upsets.

On examination she was found to be in good shape but her temperature was 39°C and she looked somewhat pale. There was marked tenderness and guarding in the right lower quadrant of the abdomen. A diagnosis of acute appendicitis was made and retrocaecal obstructive appendicitis was found at operation. Histological examination of the removed organ revealed a papillary adenocarcinoma in its middle, proliferating in the lumen, infiltrating the wall and extending to the serous coat. The diagnosis was revised to adenocarcinoma of the appendix presenting as acute appendicitis.

Adenocarcinoma of the appendix is rare and Hughes in 1951 accepted only 19 cases as genuine ones. It is forty to fifty times less common than carcinoid. It is, of course, a cancer of the right colon and the orthodox treatment is right hemi-colectomy. The patient was accordingly prepared for this operation and she was given two units of packed cells because her Hb level was only 60%: this anaemia was not investigated.

At operation on 24.1.74 a hard mass was felt at the hepatic flexure and there

was an adjacent solid piece of omentum. A full examination revealed no other abnormality. The excised bowel was sent for histological examination. The report read: "an annular infiltrative tumour with stenosis of the bowel over a segment 2.5 cm long, at a point 4 cm away from the distal line of excision. Adenocarcinoma replaces normal architecture of colon: it permeates omental tissues. Much necrosis is present at both sites." The diagnosis was once again revised, to multiple cancer of the colon, hepatic flexure and appendix.

Cancer is more frequently multiple in the colon than in any other organ, and in 3% of the patients who suffer from cancer of the colon the tumour is multiple. Multiple cancers may occur with no signs of adenomas or polyps as in this case. It is always difficult in any organ to say whether multiple cancers are all primary or whether one is primary and the others secondary since the problems of growth, local spread and metastases of malignant neaplasms are often bizarre and unpredictable. Billroth's 3 postulates are only applicable in cases where the multiple tumours affect different organs. The best criterion of multiplicity is Mercanton's: if after removal of the two or more cancers the patient remains free from disease the two growths are independent and both may be considered primary. Even this is not an absolute criterion. It is certainly not applicable in this case for the patient was readmitted 4 months after her second operation with signs and symptoms of subacute obstruction. She improved on conservative treatment but died suddenly on 19th May 1974. A postmortem exmination was not carried out.

We are reasonably sure that in this case we were dealing with a multiple large bowel cancer, a condition first described by Czerny in 1880.

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